Washington State Department of Health
Mental Health Program
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Out of State Verification of Registration / Certification / License as a Mental Health Counselor

Applicant Name: _____ Birthdate: _____ mm/dd/yyyy

I,_____ , Secretary of _____,

hereby certify that _____ Official Name of Board

was granted state ☐ Registration ☐ Certificate ☐ License
Number:_____ to practice _____

in the State of _____ on the _____ day of_____ , 20 _____ .

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

On the basis of: _____

_____

Did applicant take and pass the NBCC Exam?

☐ Yes	☐ No	Passing Score:
☐ Yes	☐ No	100 hours immediate postgraduate supervision with an approved licensed mental health practitioner or equally qualified licensed mental health practitioner.
☐ Yes	☐ No	3000 hours supervised postgraduate experience with approved licensed mental health practitioner or equally qualified licensed mental health practitioner 1200 hours must be direct counseling with individuals, couples, families or groups.
☐ Yes	☐ No	36 months full time counseling with a qualified licensed mental health counselor.

Status of License: ☐ Current Expiration Date: _____

☐ Expired Date: _____

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_____
Official Name of Board Telephone Number

_____
Secretary

_____
Date Certification Prepared